



**Washington State EHR Incentive Program**  
**WHITE PAPER #1: EP Patient Volume Calculations**

*Created April 2011; Updated April 2016*

Pg. 1-Introduction  
Pg. 2- Reporting Methods  
Pg. 3- Criteria for using Group Proxy and Panel Method  
Pg. 4- FQHCs/RHCs

## INTRODUCTION

Each year of participation, a Medicaid provider must meet patient volume requirements, as follows: (Patient volume is taken from a continuous 90-day period in the preceding calendar year OR preceding 12 months)

Entity Type	Minimum 90-day Medicaid Patient Volume Threshold
Physicians (Including Osteopathic and Naturopathic Physicians)	30%
Pediatricians (any medical provider with a Pediatrician Taxonomy that sees primarily pediatrics – dentist's not included)	20%-29% reduced payment and 30% full payment
Dentists	30%
Certified Nurse Midwives	30%
Physician Assistants (PAs) practicing at an FQHC/RHC led by a PA	30%
Nurse Practitioner	30%

**Do you provide more than 90% of your services in an in-patient hospital or ER? If yes, you are not eligible to attest.**

Hospital-Based means a professional furnishes ninety percent (90%) or more of their Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital (verified by claims analysis).

Patient volume is calculated by dividing the number of **Medicaid encounters** (in the chosen 90-day period) by the total number of **total encounters** in that same period. This is to include Medicaid Managed Care Plans.

**Example:** 30 Medicaid Encounters / 100 Total Encounters = .30 (30%)

\*\*\*You will not include “state funded only” Medicaid Encounters (such as CHIP [Title XXI], Medical Care Services [formerly called Disability Lifeline], etc.). These programs are not federally funded and covered by state funds only. Only title XIX programs are included.

We realize practices cannot always distinguish between these different funding sources. To overcome this complication, the State is providing a “multiplier” — calculated from statewide data—that deducts an estimation of non-Medicaid encounters from the general “medical assistance” totals of the practice. This multiplier is .95. Example: 30 Medicaid Encounters x .95 = 28.50 encounters, rounded to nearest whole number is 28 Medicaid Encounters.

**Retaining an Audit Trail:** All patient volume data and calculations should be supported and documented for the following reasons:

- Provide the data upon request or in an audit
- Identify the specific data sources and documenting the processes by which patient volume was determined.

**Definition of a Medicaid encounter:**

- A Medicaid encounter is an encounter with a Medicaid eligible client, paid or unpaid. You may also include Medicaid Managed Care (not CHIP) encounters. They must be Medicaid eligible on the date of the encounter.

**Border Areas:** You can include encounters in Border States (Oregon and Idaho), as long as you identify them by indicating this on your application.

## REPORTING METHODS

### **Individual Encounters:**

Encounters incurred “only” by the attesting EP. If you are a “group practice,” keep in mind that all EPs in your group will also have to attest as individuals. Whether you choose INDV or Group Proxy, your whole group must follow the same method. See below for definition of a “group.”

### **Group Proxy Method:**

This method uses the encounters from the whole “organization/group” to establish an average for each EP. See section below for specific criteria. \*(see below)

### **Panel Method:**

“Encounter” under a Managed Care or similar structure with capitation or case assignment. This method is an option for providers that see mostly Medicaid Managed Care clients, but don’t have enough encounters to meet 30%. See section below for specific criteria.

## Criteria for Using Group Proxy and the Panel Method

### **Group Proxy Method:**

This method uses the encounters from the whole “organization/group” to establish an average for each EP.

- All EPs in the group practice or clinic must use the same methodology for the payment year (individual or group proxy).
- The clinic or group practice uses the entire group or clinic’s patient volume and does not limit patient volume in any way. This means you include encounters for ALL providers, even those who are not attesting or not an eligible provider type to attest. (\*For example: RNs, Hygienists, etc., who are not eligible for the program, but have an encounter with your patient).
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.

Although the patient volume for the *entire practice* is used (*including patient encounters with non-EPs*), if the proxy calculation results in 30% Medicaid patient volume, only EPs who see Medicaid patients would be eligible for an incentive payment (see additional information regarding EPs in FQHCs and RHCs below).

- **What is “a group” for the purposes of attesting with Group Proxy?**
  - This principle encourages more liberal definitions of “clinic,” “group,” and “practice.”
  - In Washington State, a “group” is any consistent, coherent, and reasonable association of EPs who are part of the same healthcare organization, including:
    - The entire organization
    - A subset of the entire organization, like a physical practice site, or the EPs in one city or county or region
    - By specialty
    - Other logical alignments upon approval by the State.
- **What is NOT “a group”?**
  - Random EPs from multiple practice sites, associated only for the purpose of calculating a qualifying patient volume threshold
  - EPs associated into groups according to inconsistent rationale: by site here, by specialty there, and by region somewhere else

#### **Patient Panel Method:**

CMS allows a calculation meant to capture Medicaid enrollees assigned to an EP’s panel within the 90-day period, while also accounting for additional unduplicated Medicaid encounters with patients *not* on the EP’s panel. MCO panels are only for Primary Care Physicians that have patients assigned to them as a PCP. The encounters in this section are not total group encounters, but individual only. This calculation is as follows:

**Total Medicaid** (or Needy Individual if you practice in a FQHC/RHC) patients assigned to the provider (in 90-day period) with at least one encounter in the prior year

+

Unduplicated\*\* Medicaid (or Needy Individual if FQHC/RHC) encounters

This sum is divided by:

**Total patients** (including Medicaid) assigned to the provider with at least one encounter in the prior year

+

Unduplicated encounters

**\*\*Unduplicated means:** a patient counted as assigned to a provider that also had an encounter should only be counted once in the calculation.

## FQHC/RHC

(Federally Qualified Healthcare Center (including Tribal Clinics) /Rural Health Clinic)

EPs who provide over 50% of their services in an FQHC or RHC during a six month period are the only EPs who can meet their patient volume threshold using “**medically needy individual**” encounters with non-Medicaid patients. Types of encounters used in to calculate the Medicaid volume using the medically needy method:

- **Medicaid encounters**
- **CHIP encounters**
- **Charity Care encounters:** The services were furnished at no cost, by agreement of the clinic in writing prior to the encounter. Note: being unable to collect on a debt does not constitute Charity Care.
- **Sliding Fee Scale encounters:** The services were paid for at a reduced cost based on an established sliding scale determined by the individual’s ability to pay prior to the encounter.

*\*\*For purposes of calculating needy individual volume, Basic Health clients do not qualify.*

***\*\*See White Paper #7 for more information regarding FQHC/RHCs***